Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY PUBLIC

October 22, 2024

[redacted], VP OF OPERATIONS
701 LANSDALE OPERATING LLC
701 LANSDALE AVENUE
LANSDALE, PA, 19446

RE: ST. MARY VILLA FOR INDEPENDENT
& RETIREMENT LIVING
701 LANSDALE AVENUE
LANSDALE, PA, 19446
LICENSE/COC#: 14107

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/10/2024, 07/11/2024 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *ST. MARY VILLA FOR INDEPENDENT & RETIREMENT LIVING* **License #**: *14107* **License Expiration**: *11/03/2024*

Address: *701 LANSDALE AVENUE, LANSDALE, PA 19446*

County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *701 LANSDALE OPERATING LLC*

Address: *701 LANSDALE AVENUE, LANSDALE, PA, 19446*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *05/26/1992* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *72* **Waking Staff**: *54*

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Renewal* **Exit Conference Date**: *07/11/2024*

Inspection Dates and Department Representative

07/10/2024 - On-Site: [redacted]

07/11/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *90* **Residents Served**: *56*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *St. Camillus* **Capacity**: *20* **Residents Served**: *16*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *56*

Diagnosed with Mental Illness: *6*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *16*

Have Physical Disability: *0*

Inspections / Reviews

07/10/2024 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/03/2024*

Inspections / Reviews *(continued)*

08/08/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *09/05/2024*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *08/13/2024*

08/14/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *09/05/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *09/13/2024*

10/22/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *09/05/2024*

Reviewer: [redacted] **Follow Up Type:** *Not Required*

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted], resident #1 was found on the floor in the dining room. The home did not report this incident to the department until [redacted]

Plan of Correction ***Accept ([redacted] - 08/14/2024)***

Incident for Resident#1 that occurred on [redacted] was submitted on [redacted].
Audit will be completed by RCC on 8/5/2024 to ensure that all reportable incidents have been submitted timely.
Education was provided to RCC by Administrator on 7/30/2024 on reporting process. RCC will provide education to all staff on 8/5/2024 on the reporting process to ensure all reportable incidents are reported within the 24hr time frame.
Weekly Audit x 4 weeks will be completed by RCC starting 8/5/2024 and reported /submitted to Administrator for QAPI. Daily audits will be conducted by RCC starting 8/5/2024 to ensure that all reportables are reported timely.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented ([redacted] - 10/08/2024)

18 - Compliance With Laws

2. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Boiler SN# 240795b was inspected by PA Dept of L&I on 6/4/24- and failed the inspection. The previous certificate expired on 1/11/2024. The boiler is currently in use but has not been fully repaired.

Plan of Correction ***Accept [redacted] - 08/14/2024)***

Boiler SN# 240795b is scheduled for repair on 8/5/24.
Audit was completed by the Maintenance Director on 7/30/2024 for all boilers to ensure that facility remains in compliance.
Education was provided to the Director of Maintenance on 7/30/2024 on the importance of remaining in compliance. The Maintenance Director provided education to all staff on 7/31/24 to ensure that facility remains in compliance.
Weekly Audit x 4 weeks will be completed by Director of Maintenance starting 8/5/2024 and reported /submitted to Administrator for QAPI. Daily audits will be conducted by Director of Maintenance starting 8/5/2024 to ensure that all boilers are operating properly.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented ([redacted] - 10/08/2024)

25b - Contract Signatures

3. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated [redacted], for resident #2 was not signed by the resident.

The resident-home contract, dated [redacted], for resident #3 was not signed by the home.

Repeat Violation Date: 2/6/23 et al.

Plan of Correction ***Accept ([redacted] - 08/14/2024)***

The Admissions Director met with (Resident #2) and explained the admission contract. The Admissions Director signed the contract on the wrong signature line (Resident#3) Correction was made by The Director of Admissions. Audit will be completed by Admission Director for all admissions as of 1/1/24 starting 8/5/2024 to ensure that all residents have at least 3 attempts to sign prior to POA and all signatures are in accurate location on contract. Education was provided by the Administrator to the Admissions Director and RCC on 7/30/2024 on the importance of ensuring that residents are given the opportunity to sign admission contracts as well as signatures are in correct locations on the contract.
Weekly Audit x 4 weeks will be completed by Admission Director starting 8/5/2024 and reported /submitted to Administrator for QAPI. Monthly audits will be completed by Admissions Director starting 8/5/2024 to ensure that all residents have at least 3 attempts to sign prior to POA and all signatures are in accurate location on contract.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented ([redacted] - 10/08/2024)

41e - Signed Statement

4. Requirements

2600.
41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident 2's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Resident 3's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Resident 4's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Plan of Correction ***Accept ([redacted] - 08/14/2024)***

Resident rights are listed in our Admission Agreement. The Admissions Director met with (Resident #2, Resident#3, Resident#4) and reviewed with each of them their resident rights. The Admissions Director made three attempts to

41e Signed Statement (continued)

have them sign the resident rights section of the contract.
Audit will be completed on 8/5/2024 by Admission Director for all admissions as of 1/1/24 to ensure that all residents have at least 3 attempts to sign prior to POA.
Education was provided by the Administrator to the Admissions Director and RCC on 7/30/2024 on the importance of ensuring that residents are given the opportunity to sign admission contracts as well as signatures are in correct locations on the contract.
Weekly Audit x 4 weeks will be completed by Admission Director starting 8/5/2024 and reported /submitted to Administrator for QAPI. Monthly audits will be completed by the Admissions Director starting 8/5/2024 to ensure that all residents have at least 3 attempts to sign prior to POA and all signatures are in accurate location on contract.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented (- 10/08/2024)

63a - First Aid/CPR Training

5. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On , from , 56 residents were present in the home. During this time only 1 staff person was present in the home who is certified in CPR/First Aid.

Plan of Correction ***Accept - 08/14/2024)***

**(Dispute) On 6/28/2024 we did have two employees on this shift that are CPR certified.*
The employee identified has a CPR certification.
The audit was completed by RCC on 7/30/2024 to ensure that we have 2 employees that are CPR Certified each shift when census is above 50.
Education was provided to RCC and scheduler on the importance of ensuring that there are 2 employees that are certified each shift when census is above 50.
Weekly Audit x 4 weeks will be completed by Staffing Coordinator starting 8/5/2024 and reported /submitted to Administrator for QAPI. Daily audits will be completed by the Staffing Coordinator starting 8/5/2024 to ensure that there are 2 employees that are CPR Certified each shift when census is above 50.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented (- 10/08/2024)

65a - FS Orientation 1st Day

6. Requirements

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:
1. Evacuation procedures.

65a FS Orientation 1st Day *(continued)*

2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person A, whose first day of work was [redacted], did not receive orientation on the following topics:
1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Staff person B, whose first day of work was [redacted], did not receive orientation on the following topics:
1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Staff person C, whose first day of work was [redacted], did not receive orientation on the following topics:
1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Plan of Correction ***Accept [redacted]S - 08/14/2024)***

Orientation list has been updated to identify covered education topics. Staff Member A,B,and C were provided education(See attached audit).
Audit was completed on 7/30/2024 by Staffing Educator to ensure all staff are up to date on mandatory educations. The Administrator provided education to Director of Human Resources, RCC, Maintenance Director, and Staff Educator on 7/30/2024.
Weekly Audit x 4 weeks will be completed by Staffing Educator starting 8/5/2024 and reported /submitted to Administrator for QAPI. Weekly audits will be completed by the Staffing Educator starting 8/5/2024 to ensure that new hires have completed mandatory education.

65a - FS Orientation 1st Day *(continued)*

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented [redacted] - 10/22/2024)

65b - Rights/Abuse 40 Hours

7. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person A completed his/her 40th scheduled work hour in March of 2023 . However, this staff person did not complete training in the following topics:
2. Emergency medical plan.
4. Reporting of reportable incidents and conditions

Staff person B completed his/her 40th scheduled work hour in September of 2023 . However, this staff person did not complete training in the following topics:
2. Emergency medical plan.
4. Reporting of reportable incidents and conditions

Staff person C completed his/her 40th scheduled work hour in April of 2024 . However, this staff person did not complete training in the following topics:
2. Emergency medical plan.
4. Reporting of reportable incidents and conditions

Plan of Correction ***Accept ([redacted] - 08/14/2024)***

Staff Member A and B were provided education on Residents Rights, Mandatory reporting within the 40 scheduled working hours. Staff Educator completed Emergency Medical Plan education on 8/2/2024. Staff Educator provided education on Reporting of reportable incidents and conditions to Staff Member A and B. Staff Member C has been removed from the schedule. Mandatory Tracker has been updated. Staff Educator completed Emergency Medical Plan education on 8/2/2024.
Audit was completed by Staff Educator on 7/31/2024 to ensure that all educations have been completed.
The Administrator provided education to Director of Human Resources, RCC, Maintenance Director, and Staff Educator on 7/30/2024.
Weekly Audit x 4 weeks will be completed by Staffing Educator starting 8/5/2024 and reported /submitted to Administrator for QAPI. Weekly audits will be completed by the Staffing Educator starting 8/5/2024 to ensure that new hires have completed mandatory educations.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented ([redacted] - 10/22/2024)

65d - Initial Direct Care Training

8. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person C, hired on [redacted], began providing unsupervised ADL services on [redacted]. However, the home does not have proof that the staff person completed and passed the Department-approved direct care training course.

Repeat Violation Date: 2/6/23 et al

Plan of Correction ***Accept ([redacted] - 08/14/2024)***

Audit was completed on 7/30/2024 by RCC to ensure that all current education logs are documented correctly.
Employee training logs have been updated by RCC on 7/30/2024 to reflect each individual employee's log.
The Administrator provided education to RCC on 7/30/2024 on the importance of ensuring training schedule log documentation accuracy.
Weekly Audit x 4 weeks will be completed by RCC starting 8/5/2024 and reported /submitted to Administrator for QAPI. Weekly audits will be completed by the RCC starting 8/5/2024 to ensure that all mandatories have been completed timely.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented ([redacted] - 10/22/2024)

65e - 12 Hours Annual Training

9. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct care staff person D received only 11 hours of annual training in training year 2023.

Plan of Correction ***Accept [redacted] - 08/14/2024)***

(Dispute) Staff Member D has completed 12 hours of mandatory training. May/June are combined.
Audit was completed by RCC on 7/30/2024 to ensure that all mandatory educations were completed.
The Administrator provided education to Staff Educator and RCC on 7/30/2024 on the importance of ensuring all mandatory training is completed annually.
Weekly Audit x 4 weeks will be completed by Staff Educator starting 8/5/2024 and reported /submitted to Administrator for QAPI. Monthly audits will be completed by the Staffing Educator starting 8/5/2024 to ensure that all mandatories have been completed timely.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented ([redacted] - 10/22/2024)

65f - Training Topics

10. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person D did not receive training in the following areas during the 2023 training year:

1. Medication self-administration training.

2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.

5. Personal care service needs of the resident.

6. Safe management techniques.

7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home

Plan of Correction ***Accept [redacted] - 08/14/2024)***

Staff person D will be completing additional training for this training year (Please see attached trainings to be used)
Audit was completed by Staff Educator on 7/30/2024 to ensure that all mandatory educations were completed.
The Administrator provided education to Staff Educator and RCC on 7/30/2024 on the importance of ensuring all mandatory training is completed annually.
Weekly Audit x 4 weeks will be completed by Staff Educator starting 8/5/2024 and reported /submitted to Administrator for QAPI. Weekly audits will be completed by the Staff Educator starting 8/5/2024 to ensure that all mandatories have been completed timely.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented ([redacted] - 10/22/2024)

66b - Training Plan Content

11. Requirements

2600.
66.b. The plan must include training aimed at improving the knowledge and skills of the home's direct care staff persons in carrying out their job responsibilities. The staff training plan must include the following:

1. The name, position and duties of each direct care staff person.
2. The required training courses for each staff person.
3. The dates, times and locations of the scheduled training for each staff person for the upcoming year.

Description of Violation

The home's staff training plan does not include:

2. The required training courses for each staff person.

66b - Training Plan Content *(continued)*

Plan of Correction ***Accept (- 08/14/2024)***

Audit was completed on 7/30/2024 by RCC to ensure that all current education logs are documented correctly.
Employee training logs have been updated by RCC on 7/30/2024 to reflect each individual employee's log.
The Administrator provided education to RCC on 7/30/2024 on the importance of ensuring training schedule log documentation accuracy.
Weekly Audit x 4 weeks will be completed by RCC starting 8/5/2024 and reported /submitted to Administrator for QAPI. Weekly audits will be completed by the RCC starting 8/5/2024 to ensure that all mandatories have been completed timely.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented (- 10/22/2024)

81a - Accomodation

12. Requirements

2600.
81.a. The home shall provide or arrange for physical site accommodations and equipment necessary to meet the health and safety needs of a resident with a disability and to allow safe movement within the home and exiting from the home.

Description of Violation

A full length Bed Rail is present on the right side of the residents bed in room #10. The bed rail slides under mattress on two thin poles and is not securely fastened to the bed frame. The rail is easily pushed out from under the mattress creating hazardous conditions for the resident.

Plan of Correction ***Accept (- 08/14/2024)***

Bed rail of room #10 was immediately removed.
Audit was completed on 7/30/2024 by Director of Maintenance to ensure that residents with bed rails are in compliance.
The Administrator provided education to RCC and Maintenance Director on the importance of maintaining resident safety on 7/30/2024. Education has been provided to Maintenance Department, Housekeeping Department, and the Direct Care staff on 7/30/2024 and will be ongoing.
Weekly Audit x 4 weeks will be completed by Director of Maintenance starting 8/5/2024 and reported /submitted to Administrator for QAPI. Monthly audits will be completed by the Director of Maintenance starting 8/5/2024 to ensure that facility remains in compliance.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented - 10/22/2024)

82a - Poisonous Materials

13. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

In the trash room located near the entrance to the St. Lucy's wing, there was a purple spray bottle filed with an

82a Poisonous Materials (continued)

unknown purple liquid present on the bottom shelf of a utility cart. The bottle is not labeled.

Plan of Correction ***Accept (- 08/14/2024)***

Liquid was immediately removed and discarded.
Audit was completed on 7/30/2024 by Environmental Services Director to ensure that all chemicals are stored in their original, labeled containers.
The Administrator provided education on 7/30/2024 to RCC, Maintenance Director, and Environmental Services Director on the importance of proper storage and labeling of poisonous materials. Education has been provided to Maintenance Department, Dietary Department, Housekeeping Department, and the Direct Care staff on 7/30/2024 and will be ongoing.
Weekly Audit x 4 weeks will be completed by Director of Environmental Services starting 8/5/2024 and reported /submitted to Administrator for QAPI. Daily audits will be completed by the Director of Environmental Services starting 8/5/2024 to ensure that all chemicals are stored in their original, labeled containers.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented (- 10/22/2024)

82c - Locking Poisonous Materials

14. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 7/11/24, a can of Raid Ant and Roach Spray was present in the cabinet next to the stove in the unlocked trash room in the St. Camillus Wing. The product had a manufacturer's label indicating "immediately call poison control center or doctor if ingested," and was unlocked, unattended, and accessible to residents in the St. Camillus wing. Not all the residents of the home, including the residents of the St. Camillus wing, have been assessed as capable of recognizing and using poisons safely.

Plan of Correction ***Accept - 08/14/2024)***

The spray was immediately removed and discarded.
Audit was completed on 7/30/2024 by RCC to ensure all chemicals that are considered poisonous are stored in secure location.
The Administrator provided education to RCC, Maintenance Director, and Environmental Services Director on the importance of proper storage and labeling of poisonous materials on 7/31/2024. Education has been provided to Maintenance Department, Dietary Department, Housekeeping Department, and the Direct Care staff on 7/31/2024 and will be ongoing.
Weekly Audit x 4 weeks will be completed by RCC starting 8/5/2024 and reported /submitted to Administrator for QAPI. Daily audits will be completed by the RCC starting 8/5/2024 to ensure that all chemicals that are considered poisonous are stored in a secure location.

Licensee's Proposed Overall Completion Date: *09/04/2024*

82c - Locking Poisonous Materials *(continued)*

Implemented (- 10/22/2024)

85a - Sanitary Conditions

15. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 7/11/24, shower room #2 in the St. Camillus wing had rust stains on the tile flooring of the shower in several locations. The blue vent in the shower also has rust buildup on the vent slots in the same shower area.
on 7/11/24, in the women's tub room in the St. Camillus wing, there was a discarded article of clothing hanging on a stored wheelchair in room as well as an unlabeled pink and white bath sponge present on a shower chair.

On 7/11/24 in the St. Anne's wing of the home, the trash/storage room near room 54 is littered with debris including a pair of used gray rubber gloves, hair net, broken black pieces of plastic and several larger items including tables and chairs that are cluttered around the space.

Plan of Correction ***Accept (- 08/14/2024)***

The shower room was immediately cleaned and sanitized by the Environmental Services Director. Vent was immediately de-rusted by the Environmental Services Director. The article of clothing was immediately removed. The storage room has been re-organized and cleaned.
Audit was completed on 7/31/2024 by Environmental Services Director to ensure all storage rooms are free of debris. Audit was completed on 7/31/2024 by Director of Maintenance to ensure that all vents are free of rust. Audit was completed on 7/31/2024 by RCC to ensure residents personal belongings are properly stored.
The Administrator provided education to RCC, Maintenance Director, and Environmental Services Director on the importance of maintaining sanitary conditions on 7/31/2024. Education has been provided to Maintenance Department, Housekeeping Department, and the Direct Care staff on 7/31/2024 and will be ongoing.
Weekly Audit x 4 weeks will be completed by Environmental Services Director, RCC, and Director of Maintenance starting 8/5/2024 and reported /submitted to Administrator for QAPI. Daily audits will be completed by the Environmental Services Director, RCC, and Director of Maintenance starting 8/5/2024 to ensure that facility remains in compliance.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented (- 10/22/2024)

95 - Furniture and Equipment

16. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 7/10/24 ,a clothes washer was found to be leaking water onto the floor in the St. Lucy's wing..

On 7/11/24, the towel bar for in room 66b was broken off the wall and was resting on the floor of the bathroom.

95 - Furniture and Equipment *(continued)*

Plan of Correction ***Accept (- 08/14/2024)***

The identified leak and towel rack (66B) was immediately repaired by the Maintenance Director.
Audit was completed on7/30/2024 by Director of Maintenance to ensure the facility remains in compliance.
The Administrator provided education to RCC, Maintenance Director, and Environmental Services Director on the importance of maintaining good repair of furniture and equipment on 7/31/2024. Education has been provided to Maintenance Department, Housekeeping Department, and the Direct Care staff on 7/31/2024 and will be ongoing.
Weekly Audit x 4 weeks will be completed by Director of Maintenance starting 8/5/2024 and reported /submitted to Administrator for QAPI. Weekly audits will be completed by the Director of Maintenance starting 8/5/2024 to ensure that the facility remains in compliance.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented - 10/22/2024)

100b - Removal Snow/Obstructions

17. Requirements

2600.
100.b. The home shall ensure that ice, snow and obstructions are removed from outside walkways, ramps, steps, recreational areas and exterior fire escapes.

Description of Violation

On 7/10/24 at approximately 10am, multiple tree branches and sticks were found in the walkways of the St. Camillus wing activities courtyard, which is also marked as an emergency exit.

Plan of Correction ***Accept - 08/14/2024)***

Tree branches and sticks were immediately removed by the Maintenance Director.
Audit was completed by Maintenance Director on 7/30/2024 to ensure that area was free of obstructions.
The Administrator provided education to the Maintenance Director on the importance of maintaining obstruction free walkways on 7/31/2024. Education has been provided to Maintenance Department, Housekeeping Department, and the Direct Care staff on 7/31/2024 and will be ongoing.
Weekly Audit x 4 weeks will be completed by Director of Maintenance starting 8/5/2024 and reported /submitted to Administrator for QAPI. Weekly audits will be completed by the Director of Maintenance starting 8/5/2024 to ensure that facility remains in compliance.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented (- 10/22/2024)

107d - Procedure Emergency Management Agency Submission

18. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home could not provide proof that they have submitted their emergency procedures to the Emergency Management Agency. The home provided a copy of typed letters dated 1/5/23 and 1/10/24 to the Emergency

107d - Procedure Emergency Management Agency Submission (continued)

Management Director of Montgomery County; however, there is no proof or confirmation that these letters had actually been sent.

Plan of Correction ***Accept [redacted] - 08/08/2024)***

The emergency procedure manual was re-sent on 8/2/2024.
The Administrator provided education to the Maintenance Director on the importance of annual submission of the Emergency Management Procedures on 7/31/2024.
Weekly Audit x 4 weeks will be completed by Director of Maintenance starting 8/5/2024 and reported /submitted to Administrator for QAPI. Monthly Audits will be completed by the Maintenance Director to ensure that all regulatory document submissions are submitted timely starting 8/5/2024.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented [redacted] - 10/22/2024)

132a - Monthly Fire Drill

19. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

The home had "N/A" or Not Applicable written for evacuation time and and for number of residents evacuated on the fire drill records for drills done on 5/31/24 at 0430, 7/17/23 at 0400 and 8/29/23 at 1600 indicating that fire drills were not actually conducted or that drills were conducted incorrectly on those dates.

Plan of Correction ***Accept [redacted] - 08/08/2024)***

Fire Drill was conducted on 7/12/2024 by the Maintenance Director.
An audit was completed by the Maintenance Director on 7/30/2024 to ensure all sheets have been completed accurately.
The Administrator provided education to the Maintenance Director on the importance of holding monthly fire drills on 7/31/2024.
Weekly Audit x 4 weeks will be completed by Director of Maintenance starting 8/5/2024 and reported /submitted to Administrator for QAPI. Monthly Audits will be completed by the Maintenance Director starting 8/5/2024 to ensure that all documents have been accurately completed.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented [redacted] - 10/22/2024)

132c - Fire Drill Records

20. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the drill conducted on 7/17/23 does not include an evacuation time, exit route used or number

132c Fire Drill Records (continued)

of residents evacuated.

The fire drill record for the drill conducted on 8/29/23 does not include an evacuation time, exit route used or number of residents evacuated.

The fire drill record for the drill conducted on 10/12/23 does not include exit route used, number of residents evacuated or number of staff participating.

The fire drill record for the drill conducted on 11/19/23 does not include an exit route used.

The fire drill record for the drill conducted on 5/31/24 does not include an evacuation time or exit route used.

Repeat Violation: 2/6/23 et al.

Plan of Correction ***Accept (- 08/08/2024)***

An audit was completed by the Maintenance Director on 7/31/2024 to ensure all sheets have been completed accurately.
The Administrator provided education to the Maintenance Director on the importance of holding monthly fire drills on 7/31/2024.
Weekly Audit x 4 weeks will be completed by Director of Maintenance starting 8/5/2024 and reported /submitted to Administrator for QAPI. Monthly Audits will be completed by the Maintenance Director starting 8/5/2024 to ensure that all documents have been accurately completed.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented - 10/22/2024)

132d - Evacuation

21. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The home indicated that no residents were evacuated as required during the following fire drills: 7/17/23; 8/29/23; 10/12/23; 11/19/23; 12/29/23; 1/30/24; 5/31/24; 6/1/24.

Plan of Correction ***Accept (- 08/08/2024)***

Fire Drill was conducted on 7/12/2024 by the Maintenance Director.
An audit was completed by the Maintenance Director on 7/31/2024 to ensure all residents were evacuated as required.
The Administrator provided education to the Maintenance Director on the importance of proper documentation on 7/31/2024.
Weekly Audit x 4 weeks will be completed by Director of Maintenance starting 8/5/2024 and reported /submitted to Administrator for QAPI. Monthly Audits will be completed by the Maintenance Director starting 8/5/2024 to ensure all residents were evacuated as required.

132d - Evacuation (continued)

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented (- 10/22/2024)

132e - Fire Drill Sleeping Hours

22. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

Overnight fire drills that occurred on 7/17/23 at 0400 and 11/19/23 at 0518 cannot be counted as the home had no evacuation time recorded for the drills. The overnight drill on 1/30/24 at 0415 cannot be counted as there was no evacuation time or number of residents evacuated listed, indicating the drill was not conducted, or that it was conducted incorrectly.

Plan of Correction ***Accept (- 08/08/2024)***

Director of Maintenance will complete fire drill during sleeping hours.
An audit was completed by the Maintenance Director on 7/30/2024 to ensure all documents have been completed accurately.
The Administrator provided education to the Maintenance Director on the importance of holding fire drills during sleeping hours on 7/31/2024.
Weekly Audit x 4 weeks will be completed by Director of Maintenance starting 8/5/2024 and reported /submitted to Administrator for QAPI. Monthly Audits will be completed by the Maintenance Director starting 8/5/2024 to ensure that all documents have been accurately completed.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented (- 10/22/2024)

132f - Alternate Exit Routes

23. Requirements

2600.
132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

"N/A" or not applicable, was recorded as the exit route used during the following fire drills: 7/17/23; 8/29/23; 10/12/23; 11/19/23.

Plan of Correction ***Accept (- 08/08/2024)***

Fire Drill was conducted on 7/12/2024 by the Maintenance Director.
An audit was completed by the Maintenance Director on 7/30/2024 to ensure alternate evacuation routes are being selected and all documents have been completed accurately.
The Administrator provided education to the Maintenance Director on the importance of selecting alternate evacuation routes on 7/31/2024.
Weekly Audit x 4 weeks will be completed by Director of Maintenance starting 8/5/2024 and reported /submitted to Administrator for QAPI. Monthly Audits will be completed by the Maintenance Director starting 8/5/2024 to ensure alternate evacuation routes are being selected and all documents have been completed accurately.

132f - Alternate Exit Routes (continued)

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented ([redacted] - 10/22/2024)

132g - Fire Drills Days/Times

24. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely holds fire drills at the end of the month as evidenced by the following drills: 12/29/23; 1/30/24; 2/28/24; 3/31/24; 4/30/24; 5/31/24.

Repeat Violation Date: 2/6/23 et al.

Plan of Correction ***Accept ([redacted] - 08/08/2024)***

Fire Drill was conducted on 7/12/2024 by the Maintenance Director.
The Administrator provided education to the Maintenance Director on the importance of holding monthly fire drills on different days of the week on 7/31/2024.
Weekly Audit x 4 weeks will be completed by Director of Maintenance starting 8/5/2024 and reported /submitted to Administrator for QAPI. Monthly Audits will be completed by the Maintenance Director starting 8/5/2024 to ensure that monthly fire drills are being held on different days of the week.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented ([redacted] - 10/22/2024)

132h - Designated Meeting Place

25. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drills on 7/17/23 at 0400, 8/29/23 at 1600, 10/12/23 at 1000, 11/19/23 at 0518, 12/29/23 at 1600, 1/30/24 at 0415, 5/31/24 at 0430, and 6/1/24 at 1614 residents did not evacuate to a designated meeting place away from the building or within the fire-safe area. Staff and residents of the home indicate that they are instructed to have residents stand at the entrance to their individual apartments when the fire alarms sounds, and do not proceed to a designated area.

Repeat Violation Date: 2/6/23 et al.

Plan of Correction ***Accept ([redacted] - 08/08/2024)***

Fire Drill was conducted on 7/12/2024 by the Maintenance Director.
The Administrator provided education to the Maintenance Director and RCC on the importance of establishing a designated meeting place during fire drills on 7/31/2024.

132h Designated Meeting Place (continued)

Education for staff/residents will be on going.
Weekly Audit x 4 weeks will be completed by Director of Maintenance starting 8/5/2024 and reported /submitted to Administrator for QAPI. Monthly Audits will be completed by the Maintenance Director starting 8/5/2024 to designated meeting place has been established.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented [redacted] - 10/22/2024)

141b1 - Annual Medical Evaluation

26. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #5's most recent medical evaluation was completed on [redacted] The resident's previous medical evaluation was completed on [redacted]

Resident #6's most recent medical evaluation was completed on [redacted]. The resident's previous medical evaluation was completed on [redacted].

Plan of Correction ***Accept ([redacted] - 08/08/2024)***

Unable to make corrections to Resident #5 and Resident#6 due to evaluation being already completed.
An audit was completed by RCC on 7/30/2024 to ensure all medical evaluations are up to date.
The Administrator provided education to RCC on the importance of ensuring that residents receive medical evaluation annually on 7/31/2024.
Weekly Audit x 4 weeks will be completed by RCC starting 8/5/2024 and reported /submitted to Administrator for QAPI. Monthly Audits will be completed by RCC starting 8/5/2024 to ensure all medical evaluations are completed in a timely manner.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented [redacted] - 10/22/2024)

183e - Storing Medications

27. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On [redacted] The following medication cards were observed to have a punctured blister foil with the medication still present in the spot exposing it to contamination or improper sanitation.
Resident #3's [redacted] tab blister pack straight order medication.
Resident #3's [redacted] tab blister pack pro re nata medication.

183e Storing Medications *(continued)*

Plan of Correction ***Accept (- 08/14/2024)***

Medication for resident #3 was immediately discarded from the blister pack.
An audit was completed by RCC on 7/30/2024 to ensure that medications are stored properly.
The Administrator provided education to RCC on the importance of ensuring that medications are organized in the proper manner on 7/31/2024. RCC provided education to staff on 7/31/2024 on the importance of ensuring that medications are stored properly.
Weekly Audit x 4 weeks will be completed by RCC starting 8/5/2024 and reported /submitted to Administrator for QAPI. Monthly Audits will be completed by RCC starting 8/5/2024 to ensure all medications are stored properly.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented (- 10/22/2024)

184a - Resident's Meds Labeled

28. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

The pharmacy label for resident #2's does not include the correct instructions for administration. The current physician's order dated indicates resident #2 should be given One tablet by mouth at bedtime for . The pharmacy label indicates the resident should take half of a tablet nightly (25mg).

Plan of Correction ***Accept - 08/14/2024)***

Order was placed by family to update resident#2 medication label.
An audit was completed by RCC on 7/30/2024 to ensure that medications labels match the order given by physician. The Administrator provided education to RCC on the importance of ensuring that prescription medications are labeled correctly according to order in PCC on 7/31/2024. Education was provided to Med Tech's by RCC on 7/31/2024 on the importance of ensuring that prescription medications are labeled correctly according to order in PCC and will be ongoing.
Weekly Audit x 4 weeks will be completed by RCC starting 8/5/2024 and reported /submitted to Administrator for QAPI. Monthly Audits will be completed by RCC starting 8/5/2024 to ensure that prescription medications are labeled correctly according to order in PCC.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented (- 10/22/2024)

185a - Implement Storage Procedures

29. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

185a - Implement Storage Procedures *(continued)*

Description of Violation

Resident #2 is prescribed [redacted]. On [redacted], there were 49 tabs in the two blister packages in the narcotics locked box and a count of 50 was recorded on the narcotics record.

Resident #7 is prescribed [redacted]. On [redacted], there were 37 tabs in the two blister packs in the narcotics locked box and a count of 38 was recorded on the narcotics record.

Resident #8 is prescribed [redacted]. On [redacted], the home received a delivery of 120 pills (30 pills in each of 4 blister packages). The receipt of the medication is logged in the Narcotics Log as a receipt of 100 pills on 7/7/24. On 7/11/24, there were 120 pills available in the narcotics locked box.

Plan of Correction ***Accept ([redacted] - 08/14/2024)***

(Dispute)Resident#8 Page 28 was reviewed by surveyor which identified 100 tablets. The surveyor had blister pack number#8 which is for the same resident and medication. The page for blister pack number#8 is listed on page #8 which is listed on the top of the blister pack and not page 28.
Resident#2 and Resident#7 received medication but it was not signed out at time administered.
Education was provided by Administrator to RCC on 7/30/24 on the importance in ensuring that procedures for the safe storage, access, security, distribution and use of medications and medical equipment are being followed by trained staff persons. Education was provided to Med Tech's by RCC on 7/30/2024 on the importance of ensuring that procedures for the safe storage, access, security, distribution and use of medications and medical equipment are being followed. Education will be ongoing. Audit was completed by RCC on 8/2/24 to ensure that all documentation is accurate and matches documentation listed on Narcotic log.
Weekly Audit x 4 weeks will be completed by RCC starting 8/5/2024 and reported /submitted to Administrator for QAPI. Weekly Audits will be completed by RCC starting 8/5/2024 to ensure that procedures for the safe storage, access, security, distribution and use of medications and medical equipment are being followed

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented ([redacted] - 10/22/2024)

187d - Follow Prescriber's Orders

30. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #4 is prescribed [redacted] one tablet by mouth at bedtime, [redacted] one tablet by mouth in the afternoon, [redacted] - one drop in both eyes at bedtime, [redacted] one time a day topically, [redacted] one tablet by mouth at bedtime, [redacted] by mouth in the evening and [redacted] - 1 tablet by mouth three times per day. However these medications were not administered to the resident on [redacted]. The home was unable to provide a reason why these medications were not administered.

Repeat Violation Date: 2/6/23 et al.

Plan of Correction ***Accept ([redacted] - 08/08/2024)***

Resident#4 had no complications due to skipped medication.

187d - Follow Prescriber's Orders (continued)

An audit was completed by RCC on 7/30/2024 to ensure that residents received medications as directed from the prescriber.
The Administrator provided education to RCC 0n 7/31/2024 on the importance of following the direction of the prescriber. RCC provided education to Med Tech staff on 7/31/2024 to ensure that directions of the prescriber are being followed.
Weekly Audit x 4 weeks will be completed by RCC starting 8/5/2024 and reported /submitted to Administrator for QAPI. Monthly Audits will be completed by RCC starting 8/5/2024 to ensure that residents received medications as directed from prescriber.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented (- 10/22/2024)

31. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #2 is prescribed - 1 tablet by mouth two times per day. However, the second dose of this medication could not be administered to resident on because the medication was not available in the home.

Repeat Violation Date: 2/6/23 et al.

Plan of Correction ***Accept (- 08/08/2024)***

Medication was purchased by family.
An audit was completed by RCC on 7/30/2024 to ensure that residents received medications as directed from the prescriber.
The Administrator provided education to RCC 0n 7/31/2024 on the importance of following the direction of the prescriber. RCC provided education to Med Tech staff on 7/31/2024 to ensure that directions of the prescriber are being followed.
Weekly Audit x 4 weeks will be completed by RCC starting 8/5/2024 and reported /submitted to Administrator for QAPI. Monthly Audits will be completed by RCC starting 8/5/2024 to ensure that residents received medications as directed from prescriber.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented (- 10/22/2024)

190a - Completion Medication Course

32. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person C last completed the medication administration annual practicum on . On , only one medication administration record review was completed along with one medication pass observation; however, it was

190a - Completion Medication Course (continued)

documented on the previous annual practicum page completed 6/28/23. There were no additional observations documented to show that Staff person C has appropriately completed their annual practicum for 2024 which should have been completed by 6/28/24.
Staff person C administered medications to resident 7, including [redacted]

Plan of Correction ***Accept ([redacted] - 08/08/2024)***

Staff person C was immediately removed from the schedule.
Audit was completed on 7/30/2024 by the Human Resources Director to ensure that all staff have completed required Medication Administration courses and that all documentation is completed accurately.
The Administrator provided education to RCC and Director of Human Resources Director on 7/31/2024 on the importance of ensuring that all staff have completed medication courses timely.
Weekly Audit x 4 weeks will be completed by Human Resources Director starting 8/5/2024 and reported /submitted to Administrator for QAPI. Monthly Audits will be completed by Human Resources Director starting 8/5/2024 to ensure that all staff have completed medication courses timely.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented ([redacted] - 10/22/2024)

191 - Resident Right to Refuse

33. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #2, admitted [redacted], has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Resident #3, admitted [redacted], has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Resident #4, admitted [redacted], has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction ***Accept ([redacted] - 08/14/2024)***

The Admissions Director met with (Resident #2, Resident#3, Resident#4) and reviewed with each of them their resident rights. The Admissions Director made three attempts to have them sign the resident rights section of the contract.
Audit was completed on 8/2/2024 by Admission Director for all admissions as of 1/1/24 to ensure that all residents have at least 3 attempts to sign prior to POA.
Education was provided by the Administrator to the Admissions Director and RCC on 7/30/2024 on the importance of ensuring that residents are given the opportunity to sign admission contracts as well as signatures are in correct locations on the contract.
Weekly Audit x 4 weeks will be completed by Admission Director starting 8/5/2024 and reported /submitted to Administrator for QAPI. Weekly audits will be completed by the Admissions Director starting 8/5/2024 to ensure

191 Resident Right to Refuse (continued)

that all residents have at least 3 attempts to sign prior to POA and all signatures are in accurate location on contract.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented [redacted] - 10/22/2024)

224c - Preadmission Screening

34. Requirements

2600.
224.c. The preadmission screening shall be completed by the administrator or designee. If the resident is referred by a State-operated facility, a county mental health and intellectual disability program, a drug and alcohol program or an area agency on aging, a representative of the referral agent may complete the preadmission screening.

Description of Violation

The preadmission screening form, dated [redacted] for resident #2, admitted [redacted], was not signed by the administrator or designee.

The preadmission screening form, dated [redacted] for resident #4, admitted [redacted] was not signed by the administrator or designee.

Plan of Correction ***Accept ([redacted] - 08/08/2024)***

Pre Screening for Resident #2 and Resident#4 are unable to be signed due to previous RCC no longer being employed with facility.
Audit was completed by RCC on 8/2/2024 to ensure that all pre admission screenings have appropriate signatures.
Education was provided by the Administrator to the RCC on 7/30/2024 on the importance of ensuring that residents pre admission screenings have appropriate signatures.
Weekly Audit x 4 weeks will be completed by RCC starting 8/5/2024 and reported /submitted to Administrator for QAPI. Monthly audits will be completed by RCC starting 8/5/2024 to ensure that all residents pre admission screenings have appropriate signatures.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented ([redacted] 10/22/2024)

227g -Support Plan Signatures

35. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

The assessor did not sign the support plan for Resident #2 dated [redacted]

Resident 4 and the assessor did not sign the support plan for Resident #4 dated [redacted] and there is no indication that the resident was unable to sign or declined to participate.

227g -Support Plan Signatures (continued)

Plan of Correction ***Accept (- 08/08/2024)***

Resident#2 and Resident#4 support plan is unable to be signed by assessor due to the employee no longer being employed with facility.
Audit was completed by RCC on 8/2/2024 to ensure that all support plans have appropriate signatures.
Education was provided by the Administrator to the RCC on 7/30/2024 on the importance of ensuring that all residents support plans have appropriate signatures.
Weekly Audit x 4 weeks will be completed by RCC starting 8/5/2024 and reported /submitted to Administrator for QAPI. Monthly audits will be completed by RCC starting 8/5/2024 to ensure that all residents support plans have appropriate signatures.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented - 10/22/2024)

231e - No Objection Statement

36. Requirements

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident #2 was admitted to the Secure Dementia Care Unit (SDCU) on . The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Resident #3 was admitted to the Secure Dementia Care Unit (SDCU) on . The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Plan of Correction ***Accept (- 08/14/2024)***

The Admissions Director met with (Resident #2, Resident#3) and reviewed the admission contract with them. The Admissions Director made three attempts to have them sign the No Objection Statement. We currently use a Consent for Admission document for our memory care unit (See attached which was confirmed as approval to utilize.)
Audit was completed on 8/2/2024 by Admission Director for all admissions as of 1/1/24 to ensure that all residents have at least 3 attempts to sign prior to POA.
Education was provided by the Administrator to the Admissions Director and RCC on 7/30/2024 on the importance of ensuring that residents are given the opportunity to sign admission contracts as well as signatures are in correct locations on the contract.
Weekly Audit x 4 weeks will be completed by Admission Director starting 8/5/2024 and reported /submitted to Administrator for QAPI. Weekly audits will be completed by the Admissions Director starting 8/5/2024 to ensure that all residents have at least 3 attempts to sign prior to POA and all signatures are in accurate location on contract.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented (- 10/22/2024)

233a Lock Approval

37. Requirements

2600.
233.a. Doors equipped with key locking devices, electronic card operated systems or other devices that prevent immediate egress are permitted only if there is written approval from the Department of Labor and Industry, Department of Health or appropriate local building authority permitting the use of the specific locking system.

Description of Violation

The home does not have documentation of written approval from the Department of Labor and Industry, Department of Health or local building authority for the magnetic locks, used on the exit doors from the SDCU.

Plan of Correction ***Accept (- 08/14/2024)***

Education was provided by the Administrator to the Director of Maintenance on 7/31/2024 on the importance of having written approval for lock key devices.
The Director of Maintenance has contacted the vendor to request the letters on_8/9/2024 and will obtain a copy of approval for lock key devices by 9/4/2024.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented - 10/22/2024)

233b Lock Manufacturer Statement

38. Requirements

2600.
233.b. A home shall have a statement from the manufacturer, specific to that home, verifying that the electronic or magnetic locking system will shut down, and that all doors will open easily and immediately when one of more of the following occurs:
1. Upon a signal from an activated fire alarm system, heat or smoke detector.
2. Power failure to the home.
3. Overriding the electronic or magnetic locking system by use of a key pad or other lock releasing device.

Description of Violation

The home does not have a statement from the manufacturer of the magnetic locks in the SDCU verifying that the locks will release when the fire alarm system is activated, the home's power fails, and when the lock releasing device is operated.

Plan of Correction ***Accept (- 08/14/2024)***

Education was provided by the Administrator to the Director of Maintenance on 7/31/2024 on the importance of having written approval for lock key devices.
The Director of Maintenance has contacted the vendor to request a statement on_8/9/2024 and will obtain a copy of approval for lock key devices by 9/4/2024.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented - 10/22/2024)

234a Admission Support Plan

39. Requirements

2600.

234a Admission Support Plan *(continued)*

234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #3 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, the resident's initial support plan was completed on [redacted].

Plan of Correction ***Accept ([redacted] - 08/08/2024)***

Education was provided by the Administrator to the RCC on 7/31/2024 on the importance of completing Admission Support Plan within72 hrs. of Admission.
Audit was completed on 8/2/2024 by RCC to ensure that Admission Support Plans have been completed timely.
Weekly Audit x 4 weeks will be completed by RCC starting 8/5/2024 and reported /submitted to Administrator for QAPI. Monthly audits will be completed by RCC starting 8/5/2024 to ensure that Admission Support Plans have been completed timely.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented ([redacted] - 10/22/2024)

236 - Staff Training

40. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff person D, who works in the Secure Dementia Care Unit (SDCU) had 0 hours of training in dementia care during the 2023 training year.

Plan of Correction ***Accept ([redacted] - 08/08/2024)***

Staff person D will receive mandatory 6hr. dementia training from Staffing Educator.
Audit will be completed by Staff Educator on 8/5/2024 to ensure that Dementia training has been completed by all Direct Care Staff.
Weekly Audit x 4 weeks will be completed by RCC starting 8/5/2024 and reported /submitted to Administrator for QAPI. Monthly audits will be completed by Staffing Educator starting 8/5/2024 to ensure that Dementia training has been completed by all Direct Care Staff.

Licensee's Proposed Overall Completion Date: *09/04/2024*

Implemented ([redacted] - 10/22/2024)